ATTACHMENT 3

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Refer to: MCD-F-TGC

Region IX
Office of the
Regional Administrator
75 Hawthorne Street
San Francisco, CA 94105

MAR 0 1 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ms. S. Kimberly Belshé
Director
Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814

RE: CA-95-001-ADM

Dear Ms. Belshé:

This letter constitutes your notice of disallowance in the amount of $315,233,627 Federal financial participation (FFP) under Title XIX of the Social Security Act (the Act). These funds were claimed by the State of California and they cannot be allowed. The claims involve Medicaid administrative costs related to the Medi-Cal Administrative Claiming (MAC) system. The costs are for the period of July 1, 1992 through March 31, 1994. We deferred these claims when you submitted them earlier and we undertook an extensive review of your claim and the MAC system. Our review revealed a myriad of problems that are outlined in more detail below.

Your Department submitted a Line 7 prior period claim for $315,233,627 FFP for Medi-Cal Administrative Claiming (MAC) activities on your Quarterly Statement of Expenditures for State and Local Administration of the Medical Assistance Program (Form HCFA-64) for the quarter ended June 30, 1994. These MAC claims covered the period July 1, 1992 through March 31, 1994. A detailed schedule of the claims being disallowed is enclosed.

By letter dated October 7, 1994 you were notified of our decision to defer the entire $315,233,627 FFP in accordance with 42 CFR 430.40. This deferral was reflected in your Medicaid grant award dated October 28, 1994. By letter dated December 2, 1994, which was received by us on December 5, 1994, you provided your response to our deferral letter.

We have fully considered your December 2 response to our deferral letter. We have performed on-site reviews of the MAC claims and the MAC process in Los Angeles County (August 29 to September 1, 1994) and San Mateo and Alameda Counties (October 24-27, 1994). We have reviewed additional documentation provided by the State to our outstation staff in Sacramento. We met with State and Los Angeles County staff in San Francisco on August 17-18, 1994 and in

Washington, DC on October 18, 1994 and January 18, 1995 to discuss the MAC process. Finally, we have considered the information provided by our Office of Inspector General (OIG) regarding their review of 11 contract MAC providers in Los Angeles County which was also discussed with State staff in briefings conducted by the OIG on December 13 and 23, 1994. Based upon all of this information we are disallowing your entire claim of $315,233,627 FFP for the reasons stated below.

Applicable Law, Regulations, and Guidelines

Sections 1903(a)(2) through 1903(a)(7) of the Act identify a number of administrative costs which may be matched by the Federal government at various administrative matching rates. For the costs in issue in this claim, the statute explicitly directs payment only for costs "found necessary by the Secretary for the proper and efficient administration of the State plan." Thus the Secretary, not the individual State, determines which State administrative expenditures are to be allowed. This position is incorporated into the Medicaid regulations at 42 CFR 431.15 and 42 CFR 433.15.

Medicaid regulations at 42 CFR Parts 431 through 434 give specific guidance to States on general administration, personnel administration, fiscal administration, and contracts. Additionally, 42 CFR 430.2 provides for the applicability of 45 CFR Parts 74 and 95 to the Medicaid Program and provides guidance to the States on administration of grants. Specifically, these regulations provide as follows:

- 42 CFR 433.32 and 45 CFR 45 Parts H and I provide that States will maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable federal requirements. In addition, States are required to have: (1) accounting records which adequately identify the source and application of funds for grant and subgrant activities, (2) procedures for determining the reasonableness, allowability, and allocability of grant costs, and (3) accounting records supported by source documentation.

- 42 CFR 433.34 and 45 CFR Part 95 Subpart E provide that the State must have an approved cost allocation plan (CAP). In addition, 45 CFR 95.505 specifically excludes medical vendor payments from the definition of State agency costs that can be included in a CAP. Also, 45 CFR 95.507 requires that the CAP contain sufficient information to permit an informed judgment on the correctness and fairness of the State's procedures for allocating costs, specify the procedures used to identify, measure, and allocate all costs to each benefitting program and activity, and that all costs

claimed are supported by an adequate accounting and statistical system.

- 45 CFR 74.53 and OMB Circular A-87, Attachment A, (A)(1), which is incorporated into the Medicaid regulations at 45 CFR 74. 171, provide that State cannot claim twice for the same service or activity.

- 42 CFR 432.45 provides for claiming 75 percent FFP for skilled professional medical personnel (SPMP) and their directly supporting staff. These requirements provide that the SPMP expenditures are for activities directly related to the administration of the Medicaid program and do not include expenditures for medical assistance and that the activities claimed require professional medical knowledge and skills.

The statute provides a completely separate mechanism for payment of the Federal share of the costs of providing medical services to Medicaid recipients. Medical assistance is defined in Section 1905(a) of the Act to mean "payment of part or all of the cost of the following care and services...." The services are defined in §§ 1905(a)(1) through (25).

Under 42 CFR 447.15, a State plan must provide that the State Medicaid agency limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the State plan to be paid by the individual. There is no exemption for administrative or overhead costs to allow these costs to be claimed separately to the Medicaid program. Additionally, 42 CFR 447 Subpart B provides that the State plan must describe the policy and methods to be used in setting payment rates for each type of service in the State's Medicaid Program and that the State must maintain documentation of the payment rates and make it available upon request.

Sections 1915(g)(1) and (g)(2) specify that targeted case management can be provided as an optional service under an approved State plan. Section 4302 of the State Medicaid Manual gives guidelines on case management services and activities and acknowledges that under certain circumstances case management services may more appropriately be claimed as administrative costs. These guidelines provide that:

- Case management provided under section 1915(g) is defined as services which will assist individuals eligible under the State plan in gaining access to needed medical, social, and other services and must be documented as any other Medicaid service.

- When case management is provided as an administrative activity, the State documentation must clearly demonstrate that the activities were provided to Medicaid applicants or eligibles, and were in some way connected with determining eligibility or administering services covered under the State plan.

- Administrative case management does not include obtaining social services not covered under the State plan. Referrals for Food Stamps, energy assistance, housing, child care or legal services are not covered even if these services may be in the best interest of the recipient.

- We must evaluate the activities for which case management FFP is claimed to determine whether the claims meet the requirements for payment either at the administrative or service case management match rate.

Finally, Section 1905(a)(24)(A) prohibits payment of medical assistance costs to Medicaid eligibles who are inmates of public institutions, except medical institutions. These requirements are incorporated into the Medicaid regulations at 42 CFR 435.1008 and 435.1009.

Discussion

Claiming Medical Services as Administration

Our site visits to locations where the MAC system was in place revealed that many activities coded by hospital outpatient clinic and freestanding county public health clinic employees were already being reimbursed by Medi-Cal through the all-inclusive clinic rate as part of a clinical encounter. However, we found that these activities were also being claimed by your Department as Medi-Cal administrative activities.

We found that the physicians at the clinics performed the actual diagnosis, treatment, and prescribing functions. They then referred the patient to a physician extender, typically a registered nurse or a pharmacist. The physician extender would then explain the diagnosis and the medication to the patient, educate the patient on the health issues surrounding the diagnosis, assist the patient in making any additional appointments, make any necessary medical referrals, and provide any additional information to the patient deemed necessary. These activities are part of the standard medical protocol and as such are direct patient care services and were reimbursed as part of the fee-for-service or managed care rate. These medical services furnished by physician extenders cannot be separated from the rate paid for medical services and claimed as Medi-Cal administration.

Additionally, a significant portion of ordinary overhead activities in the outpatient clinic setting were being coded and claimed as administrative activities under MAC. For example, routine supervision, personnel activities, training, meetings, etc. were all coded as allowable MAC activities. These types of costs are included in the all-inclusive clinic services rate and should not be claimed separately.

Claiming for Targeted Case Management

The distinction between unallowable targeted case management (TCM) activities and allowable administrative case management (ACM) activities was not defined in the MAC time study coding process nor was any distinction applied by the workers in coding their activities for the MAC process. Allowable ACM activities are those which are necessary for accessing and coordinating access only to Medi-Cal State plan covered services. We found workers coding as allowable Medi-Cal ACM, activities that were well beyond the scope of Medi-Cal State plan covered services (e.g., housing referrals, social services referrals, child care referrals, energy assistance referrals, legal service referrals, and the related liaison work with agencies providing those services). Such activities are not allowable Medi-Cal expenditures except as TCM services if provided for under an approved TCM State plan amendment covering the period of the claim. California does not have an approved State plan amendment for TCM services to general outpatient populations. Therefore, only the more limited administrative case management services, not the broader TCM services, may be claimed for federal match.

Duplicate Claiming of Agency Costs

We reviewed several social service programs claiming MAC expenditures, including the Linkages and SSI Advocacy Programs, as well as 11 contracts in Los Angeles County within the Alcohol and Drug Program Administration and the Department of Mental Health. We found that these programs commonly received other Federal and State grant funds for their activities from such sources as the State Department of Aging, the Social Security Administration and various other Federal and State aging and alcohol and drug program grants. When activities of these programs were coded as allowable MAC expenditures and were also reimbursed through these other funding sources, it resulted in duplicate claims and also in claims in excess of the total costs of the programs and activities.

Another potential source of duplicate claims was identified in those counties which have contracted with managed care providers to provide Medi-Cal services. Although these contracts commonly require and pay for primary case management, there is no mechanism in the MAC coding system to identify managed care recipients in order to avoid providing and charging for duplicate services.

Broad Public Health Activities

The activities performed by County workers as part of broad public health policy initiatives are not direct Medi-Cal administrative activities and as such are not allowable. For example, school-based alcohol and tobacco prevention programs directed toward the entire school population, adult smoking cessation programs, community-based dental disease prevention programs, developmental disabilities outreach, training, and education programs, injury prevention programs, and child passenger restraint system programs, were all being coded and charged as Medi-Cal administration through the MAC process. Such public health education campaigns would only be allowable if directed toward assisting Medicaid eligible individuals to access the Medicaid program, or if they qualify as recognized Early Periodic Screening, Diagnosis and Treatment (EPSDT) outreach and education activities.

Claiming Non-Skilled Professional Medical Personnel Activities at 75 Percent Rate.

Our review found that personnel at a number of sites coded any activity performed by a physician, registered nurse, or other person designated as "skilled professional medical personnel" (SPMP) as an activity to be claimed at the enhanced SPMP matching rate of 75 percent. The 75 percent SPMP matching rate, even when applied to SPMP, is limited to those SPMP administrative functions which require the SPMP's professional medical knowledge and skills in administering the program. When SPMP are attending meetings, performing general administrative activities, doing personnel work, doing general supervisory or administrative activities, such activities are not reimbursable at 75 percent FFP.

Inmates in Public Institutions

Activities being performed by probation or correctional officers in various juvenile or adult detention facilities were being coded as allowable MAC activities. However, such detention facilities are public penal institutions, and any medical services or MAC administrative activities provided to the inmates in such public institutions are not allowable Federal Medicaid expenditures.

Time Study and MAC Code Validity

Enough of the individual MAC codes include both allowable and unallowable activities within the same code to render the entire system invalid. For example, Code 8 includes both allowable translation services and unallowable child care services. In addition, several codes indicate that activities performed by County workers related to "other State and Federal programs" are allowable MAC activities. However, only activities performed in support of the approved Medi-Cal State plan are allowable

administrative activities.

The MAC system is modeled on time study systems approved by the Departmental Appeals Board for apportioning social workers' activities to Medicaid/non-Medicaid clients. When used by clinical service providers, however, the system identifies as administrative activities many activities which are considered clinical services. For example, the Physicians' Current Procedural Terminology, Fourth Edition (CPT4), which is a commonly used system for reporting clinical activities performed by physicians for billing and other payment purposes, identifies obtaining case histories, educating patients, providing referrals to specialists, consulting with other clinicians and service providers, and counseling patients as clinical activities. As clinical activities, these functions should be included in the clinic payment rate, and not billed as Medicaid administrative costs.

The codes also fail to distinguish between activities related to administration of the provider facilities and administration of the Medicaid program. Supervision, training, and personnel functions which are required to operate the facility regardless of the number of Medicaid eligibles served are costs of administering the provider. They may not be charged separately to the Medicaid program. Medicaid administration costs, in contrast, are costs essential to administering the Medicaid program, such as facilitating eligibility determinations, or organizing programs or services required to meet federal Medicaid standards.

Claiming for Periods Without Time Study Documentation

The State's term for retroactive claims not supported by contemporaneous time study documentation is "backcasting". The issue involves a methodology for claiming costs for time periods after the effective date of the California legislation authorizing counties to claim Medicaid administrative costs, but before the MAC Manual's time reporting system was in operation. Various counties performed time studies and accumulated documentation of Medi-Cal beneficiaries receiving services for one or more quarters during the State's fiscal year ended June 30, 1993. The State proposed to project costs for a 12 month period using the data available from the last quarter of that period. The State has not provided any documentation which supports the use of time study data from current quarters to establish the allowability of the claim for prior quarters where no time study data exists.

Conclusion

This letter constitutes notice of disallowance in the amount of $315,233,627 FFP. Please make a decreasing adjustment in that amount on line 10B of your next Quarterly Medicaid Statement of Expenditures (Form HCFA-64). However, since these funds have not

been paid to the State, this adjustment will not be used in your grant award computation.

This is my final decision. Under 45 CFR Part 16, the State has an opportunity to appeal to the Departmental Appeals Board. This decision shall be the final decision of the Department unless, within 30 days after you receive this decision, you deliver or mail (you should use registered or certified mail to establish the date) a written notice of appeal to the U.S. Department of Health & Human Services, Departmental Appeals Board, Room 637-D, Hubert H. Humphrey Building, 2nd & Independence Avenue S.W., Washington, D.C. 20201. You must attach to the notice a copy of this decision, note that you intend to appeal, state the amount in dispute, and briefly state why you think that this decision is wrong. The Board will notify you of further procedures.

Please send a copy of any notice of appeal to this office.

Should you require further details regarding this matter, please contact the Acting Associate Regional Administrator for the Division of Medicaid at (415) 744-3568.

Sincerely,

Nancy Dapper

Nancy Dapper
Acting Regional Administrator

Enclosure

SUMMARY OF MAC DISALLOWANCE BY COUNTY
QUARTER ENDED JUNE 30, 1994

County	Amount
Alameda	$ 1,458,529
Amador	12,785
Calaveras	84,522
El Dorado	79,632
Fresno	422,315
Humboldt	135,734
Imperial	97,807
Inyo	22,230
Kern	847,356
Kings	12,401
Los Angeles	289,775,816
Marin	276,965
Mendocino	77,115
Merced	370,928
Napa	1,079,624
Orange	3,805,146
Placer	947,750
Riverside	1,875,815
Sacramento	165,833
San Bernardino	1,524,474
San Diego	1,187,022
San Joaquin	539,926
San Mateo	257,332
Santa Clara	1,340,058
Santa Cruz	1,328,574
Shasta	188,078
Sonoma	888,264
Stanislaus	3,075,716
Tehama	53,350
Trinity	22,673
Tulare	17,357
Tuolumne	113,610
Ventura	3,081,028
City of Berkeley	67,862
Total	$315,233,627

ATTACHMENT 4

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Refer to: MCD-F-RB
FO-D-2

Region IX
Office of the
Regional Administrator
75 Hawthorne Street
San Francisco, CA 94105

MAY 09 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ms. S. Kimberly Belshé
Director
Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814

RE: CA-95-003-ADM

Dear Ms. Belshé:

This letter constitutes your notice of disallowance in the amount of $63,509,734 Federal financial participation (FFP) under Title XIX of the Social Security Act (the Act). These funds were claimed by the State of California for Medicaid administrative costs identified through the Medi-Cal Administrative Claiming (MAC) system. The disallowed amount consists of $17,737,548 FFP claimed by your Department on Line 7 as prior period claims on Quarterly Statements of Expenditures (Form HCFA-64) for the quarters ended March 31, 1993 through March 31, 1994 (See Enclosure I) that we had tentatively allowed pending our review of supporting documentation. This disallowance also includes $10,328,174 FFP claimed on Line 7 of the HCFA-64 for the quarter ended September 30, 1994 (See Enclosure II). By letter dated February 17, 1995, HCFA notified your Department that in accordance with 42 CFR 430.40 this amount had been deferred on a grant award dated February 3, 1995. The remaining $35,444,012 FFP of this disallowance was claimed on Line 7 of the HCFA-64 for the quarter ended December 31, 1994 (See Enclosure III).

The basis for this disallowance, as discussed in detail below, is identical to that of our disallowance No. CA-95-001-ADM which was issued on March 1, 1995 and appealed by your Department to the DHHS Departmental Appeals Board in a letter dated March 30, 1995. That disallowance was based on an extensive review by HCFA of the MAC system.

In order to evaluate the propriety of the expenditures, we performed on-site reviews of the MAC claims and the MAC process in Los Angeles County (August 29 to September 1, 1994) and San Mateo and Alameda Counties (October 24-27, 1994). We reviewed additional documentation provided by the State to our outstationed staff in Sacramento. We met with representatives from the State and from Los Angeles, Napa, San Diego and San Mateo Counties in San

Francisco on July 15, 1994. Further meetings were held with State and Los Angeles County representatives in San Francisco on August 17-18, 1994, in Washington, DC on October 18, 1994 and January 18, 1995 to discuss the MAC process. Finally, we have considered the information provided by our Office of Inspector General (OIG) regarding their review of 11 contract MAC providers in Los Angeles County which was discussed with State staff in briefings conducted by the OIG on December 13 and 23, 1994.

We concluded that the MAC system as designed and implemented was so seriously flawed that we could not allow any of your Department's claims for expenditures based on this system. Accordingly, on March 1, 1995, we disallowed your Department's entire claim of $315,233,627 FFP claimed on the HCFA-64 for the quarter ended June 30, 1994. We have determined that the claims included in the current disallowance were based on your Department's MAC system. Therefore, we believe that many of the problems that we found in our previous review also exist for these claims. Accordingly, we find it necessary to issue this disallowance of $63,509,734 for the reasons stated below.

Applicable Law, Regulations, and Guidelines

Sections 1903(a)(2) through 1903(a)(7) of the Act identify a number of administrative costs related to administration of a State Medicaid plan which may be matched by the Federal government at various administrative matching rates. For the costs in issue in this claim, the statute explicitly directs payment only for costs "found necessary by the Secretary for the proper and efficient administration of the State plan." Thus the Secretary, not the individual State, determines which State administrative expenditures are to be allowed. This position is incorporated into the Medicaid regulations at 42 CFR 431.15 and 42 CFR 433.15.

Medicaid regulations at 42 CFR Parts 431 through 434 give specific guidance to States on general administration, personnel administration, fiscal administration, and contracts. Additionally, 42 CFR 430.2 provides for the applicability of 45 CFR Parts 74 and 95 to the Medicaid Program and provides guidance to the States on administration of grants. Specifically, these regulations provide as follows:

- 42 CFR 433.32 and 45 CFR 45 Parts H and I provide that States will maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable federal requirements. In addition, States are required to have: (1) accounting records which adequately identify the source and application of funds for grant and subgrant activities, (2) procedures for determining the reasonableness,

allowability, and allocability of grant costs, and (3) accounting records supported by source documentation.

- 42 CFR 433.34 and 45 CFR Part 95 Subpart E provide that the State must have an approved cost allocation plan (CAP). In addition, 45 CFR 95.505 specifically excludes medical vendor payments from the definition of State agency costs that can be included in a CAP. Also, 45 CFR 95.507 requires that the CAP contain sufficient information to permit an informed judgment on the correctness and fairness of the State's procedures for allocating costs, specify the procedures used to identify, measure, and allocate all costs to each benefitting program and activity, and that all costs claimed are supported by an adequate accounting and statistical system.

- 45 CFR 74.53 and OMB Circular A-87, Attachment A,(A)(1), which is incorporated into the Medicaid regulations at 45 CFR 74. 171, provide that State cannot claim twice for the same service or activity.

- 42 CFR 432.45 provides for claiming 75 percent FFP for skilled professional medical personnel (SPMP) and their directly supporting staff. These requirements provide that the SPMP expenditures are for activities directly related to the administration of the Medicaid program and do not include expenditures for medical assistance and that the activities claimed require professional medical knowledge and skills.

The statute provides a completely separate mechanism for payment of the Federal share of the costs of providing medical services to Medicaid recipients. Medical assistance is defined in Section 1905(a) of the Act to mean "payment of part or all of the cost of the following care and services...." The services are defined in §§ 1905(a)(1) through (25).

Under 42 CFR 447.15, a State plan must provide that the State Medicaid agency limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the State plan to be paid by the individual. There is no exemption for administrative or overhead costs to allow these costs to be claimed separately to the Medicaid program. Additionally, 42 CFR 447 Subpart B provides that the State plan must describe the policy and methods to be used in setting payment rates for each type of service in the State's Medicaid Program and that the State must maintain documentation of the payment rates and make it available upon request.

Sections 1915(g)(1) and (g)(2) of the Act specify that targeted case management can be provided as an optional service under an approved State plan. Section 4302 of the State Medicaid Manual gives guidelines on case management services and activities and acknowledges that under certain circumstances case management services may more appropriately be claimed as administrative costs. These guidelines provide that:

- Case management provided under section 1915(g) is defined as services which will assist individuals eligible under the State plan in gaining access to needed medical, social, and other services and must be documented as any other Medicaid service.

- When case management is provided as an administrative activity, the State documentation must clearly demonstrate that the activities were provided to Medicaid applicants or eligibles, and were in some way connected with determining eligibility or administering services covered under the State plan.

- Administrative case management does not include obtaining social services not covered under the State plan. Referrals for Food Stamps, energy assistance, housing, child care or legal services are not covered even if these services may be in the best interest of the recipient.

- We must evaluate the activities for which case management FFP is claimed to determine whether the claims meet the requirements for payment either at the administrative or service case management match rate.

Finally, Section 1905(a)(24)(A) of the Act prohibits payment of medical assistance costs to Medicaid eligibles who are inmates of public institutions, except medical institutions. These requirements are incorporated into the Medicaid regulations at 42 CFR 435.1008 and 435.1009.

Discussion

Claiming Medical Services as Administration

Our site visits to locations where the MAC system was in place revealed that many activities coded by hospital outpatient clinic and freestanding county public health clinic employees were already being reimbursed by Medi-Cal through the all-inclusive clinic rate as part of a clinical encounter. However, we found that these activities were also being claimed by your Department as Medi-Cal administrative activities.

We found that the physicians at the clinics performed the actual diagnosis, treatment, and prescribing functions. They then referred the patient to a physician extender, typically a registered nurse or a pharmacist. The physician extender would then explain the diagnosis and the medication to the patient, educate the patient on the health issues surrounding the diagnosis, assist the patient in making any additional appointments, make any necessary medical referrals, and provide any additional information to the patient deemed necessary. These activities are part of the standard medical protocol and as such are direct patient care services and were reimbursed as part of the fee-for-service or managed care rate. These medical services furnished by physician extenders cannot be separated from the rate paid for medical services and claimed as Medi-Cal administration.

Additionally, we found a significant portion of ordinary overhead activities in the outpatient clinic setting were being coded and claimed as administrative activities under MAC. For example, routine supervision, personnel activities, training, meetings, etc. were all coded as allowable MAC activities. These types of costs are included in the all-inclusive clinic services rate and should not be claimed separately.

Claiming for Targeted Case Management

The distinction between unallowable targeted case management (TCM) activities and allowable administrative case management (ACM) activities was not defined in the MAC time study coding process nor was any distinction applied by the workers in coding their activities for the MAC process. Allowable ACM activities are those which are necessary for accessing and coordinating access only to Medi-Cal State plan covered services. We found workers coding as allowable Medi-Cal ACM, activities that were well beyond the scope of Medi-Cal State plan covered services (e.g., housing referrals, social services referrals, child care referrals, energy assistance referrals, legal service referrals, and the related liaison work with agencies providing those services). Such activities are not allowable Medi-Cal expenditures except as TCM services if provided for under an approved TCM State plan amendment covering the period of the claim. For the periods at issue in this disallowance, California did not have an approved State plan amendment for TCM services to general outpatient populations. Therefore, only the more limited administrative case management services, not the broader TCM services, may be claimed for federal match.

Duplicate Claiming of Agency Costs

We reviewed several social service programs claiming MAC expenditures, including the Linkages and SSI Advocacy Programs, as well as 11 contracts in Los Angeles County within the Alcohol and Drug Program Administration and the Department of Mental Health.

We found that these programs commonly received other Federal and State grant funds for their activities from such sources as the State Department of Aging, the Social Security Administration and various other Federal and State aging and alcohol and drug program grants. When activities of these programs were coded as allowable MAC expenditures and were also reimbursed through these other funding sources, it resulted in duplicate claims and also in claims in excess of the total costs of the programs and activities.

Another potential source of duplicate claims was identified in those counties which have contracted with managed care providers to provide Medi-Cal services. Although these contracts commonly require and pay for primary case management, there is no mechanism in the MAC coding system to identify managed care recipients in order to avoid providing and charging for duplicate services.

Broad Public Health Activities

The activities performed by County workers as part of broad public health policy initiatives are not direct Medi-Cal administrative activities and as such are not allowable. For example, school-based alcohol and tobacco prevention programs directed toward the entire school population, adult smoking cessation programs, community-based dental disease prevention programs, developmental disabilities outreach, training, and education programs, injury prevention programs, and child passenger restraint system programs, were all being coded and charged as Medi-Cal administration through the MAC process. Such public health education campaigns would only be allowable if directed toward assisting Medicaid eligible individuals to access the Medicaid program.

Claiming Non-Skilled Professional Medical Personnel Activities at 75 Percent Rate.

Our review found that personnel at a number of sites coded any activity performed by a physician, registered nurse, or other person designated as "skilled professional medical personnel" (SPMP) as an activity to be claimed at the enhanced SPMP matching rate of 75 percent. The 75 percent SPMP matching rate, even when applied to SPMP, is limited to those SPMP administrative functions which require the SPMP's professional medical knowledge and skills in administering the program. When SPMP are attending meetings, performing general administrative activities, doing personnel work, doing general supervisory or administrative activities, such activities are not reimbursable at 75 percent FFP.

Inmates in Public Institutions

Activities being performed by probation or correctional officers in various juvenile or adult detention facilities were being coded as allowable MAC activities. However, such detention facilities are

public penal institutions, and any medical services or MAC administrative activities provided to the inmates in such public institutions are not allowable Federal Medicaid expenditures.

Time Study and MAC Code Validity

Enough of the individual MAC codes include both allowable and unallowable activities within the same code to render the entire system invalid. For example, Code 8 includes both allowable translation services and unallowable child care services. In addition, several codes indicate that activities performed by County workers related to "other State and Federal programs" are allowable MAC activities. However, only activities performed in support of the approved Medi-Cal State plan are allowable administrative activities.

The MAC system is modeled on time study systems approved by the Departmental Appeals Board for apportioning social workers' activities to Medicaid/non-Medicaid clients. When used by clinical service providers, however, the system identifies as administrative activities many activities which are considered clinical services. For example, the Physicians' Current Procedural Terminology, Fourth Edition (CPT4), which is a commonly used system for reporting clinical activities performed by physicians for billing and other payment purposes, identifies obtaining case histories, educating patients, providing referrals to specialists, consulting with other clinicians and service providers, and counseling patients as clinical activities. As clinical activities, these functions should be included in the clinic payment rate, and not billed as Medicaid administrative costs.

The codes also fail to distinguish between activities related to administration of the provider facilities and administration of the Medicaid program. Supervision, training, and personnel functions which are required to operate the facility regardless of the number of Medicaid eligibles served are costs of administering the provider. They may not be charged separately to the Medicaid program. Medicaid administration costs, in contrast, are costs essential to administering the Medicaid program, such as facilitating eligibility determinations, or organizing programs or services required to meet federal Medicaid standards.

Claiming for Periods Without Time Study Documentation

The State's term for retroactive claims not supported by contemporaneous time study documentation is "backcasting". The issue involves a methodology for claiming costs for time periods after the effective date of the California legislation authorizing counties to claim Medicaid administrative costs, but before the MAC Manual's time reporting system was in operation. Various counties

performed time studies and accumulated documentation of Medi-Cal beneficiaries receiving services for one or more quarters during the State's fiscal year ended June 30, 1993. The State proposed to project costs for a 12 month period using the data available from the last quarter of that period. The State has not provided any documentation which supports the use of time study data from current quarters to establish the allowability of the claim for prior quarters where no time study data exists.

Conclusion

This letter constitutes notice of disallowance in the amount of $63,509,734 FFP. Please make a decreasing adjustment in that amount on line 10B of your next Quarterly Medicaid Statement of Expenditures (Form HCFA-64). Once this adjustment is made, only the $17,737,548 paid to the State will be used in your grant award computation.

That portion of this disallowance, $17,737,548, which consists of FFP paid to your Department for Medicaid services furnished on or after October 1, 1980, is subject to the provisions of 42 U.S.C. 1396b(d)(5). If you choose to appeal this disallowance under 45 CFR Part 16, you have the option of retaining the $17,737,548 disallowed by this notice pending a final administrative decision. If the final decision is to the effect that any amount was properly disallowed, however, and you elected to retain the funds during the appeals process, the amount of the sustained disallowance plus interest computed pursuant to 42 U.S.C. 1396b (d)(5), will be offset in a subsequent grant award. You may exercise your option to retain the disputed funds by notifying me in writing no later than 30 days after the date this letter is received.

This is my final decision. Under 45 CFR Part 16, the State has an opportunity to appeal to the Departmental Appeals Board. This decision shall be the final decision of the Department unless, within 30 days after you receive this decision, you deliver or mail (you should use registered or certified mail to establish the date) a written notice of your appeal to the U.S. Department of Health & Human Services, Departmental Appeals Board, Room 637-D, Hubert H. Humphrey Building, 2nd & Independence Avenue S.W., Washington, D.C. 20201. You must attach to the notice a copy of this decision, note that you intend to appeal, state the amount in dispute, and briefly state why you think that this decision is wrong. The Board will notify you of further procedures.

Please send a copy of any notice of appeal to this office.

Should you require further details regarding this matter, please contact the Acting Associate Regional Administrator for the Division of Medicaid at (415) 744-3568.

Sincerely,

Nancy Dapper
Acting Regional Administrator

Enclosures

Enclosure I

SUMMARY OF MAC DISALLOWANCE BY COUNTY
FOR CLAIMS TENTATIVELY ALLOWED BY HCFA
FOR QUARTERS ENDED MARCH 31, 1993 THROUGH MARCH 31, 1994

County	Amount
Alameda	$ 2,142,567
Butte	99,933
Calaveras	16,115
Contra Costa	986,340
Fresno	115,831
Humboldt	67,439
Kern	825,173
Kings	20,845
Lassen	14,363
Madera	10,726
Marin	278,953
Mendocino	17,818
Merced	1,097,318
Monterey	625,809
Napa	194,432
Riverside	847,240
San Diego	760,032
San Francisco	2,064,547
San Joaquin	141,378
San Luis Obispo	232,349
San Mateo	999,532
Santa Barbara	432,830
Santa Clara	1,701,564
Santa Cruz	205,445
Shasta	120,120
Solano	84,370
Sonoma	242,405
Stanislaus	938,145
Sutter	22,694
Tehama	44,983
Trinity	3,324
Tulare	1,547,764
Ventura	659,709
Yolo	29,310
Yuba	93,056
City of Long Beach	53,089
Total	$17,737,548

Enclosure II

SUMMARY OF MAC DISALLOWANCE BY COUNTY
QUARTER ENDED SEPTEMBER 30, 1994

County	Amount
Amador	$ 9,422
Calaveras	1,992
Contra Costa	659,470
Glenn	36,421
Imperial	3,987
Lake	110,388
Los Angeles	1,561,343
Marin	291,578
Mendocino	52,498
Monterey	266,842
Napa	435,520
Orange	1,532,165
Placer	133,265
Riverside	726,453
San Diego	858,998
San Joaquin	183,218
Santa Clara	666,726
Santa Cruz	732,189
Shasta	99,888
Stanislaus	44,135
Sutter	298,858
Trinity	9,401
Tulare	377,173
Ventura	846,051
Yolo	390,193
Total	$10,328,174

Enclosure III

SUMMARY OF MAC DISALLOWANCE BY COUNTY
QUARTER ENDED DECEMBER 31, 1994

County	Amount
Alameda	$ 1,662,423
Amador	17,147
Butte	127,775
Calaveras	16,203
Colusa	33,344
Contra Costa	1,374,526
Del Norte	67,662
Fresno	194,101
Glenn	158,202
Humboldt	69,112
Imperial	103,453
Kern	239,175
Los Angeles	9,676,018
Madera	14,414
Marin	422,303
Mendocino	12,953
Merced	456,094
Nevada	26,306
Orange	1,134,922
Plumas	54,502
Riverside	1,292,069
Sacramento	792,767
San Bernardino	1,696,732
San Diego	462,793
San Francisco	8,963,577
San Luis Obispo	400,134
San Mateo	1,791,040
Santa Barbara	1,057,478
Santa Clara	1,261,062
Santa Cruz	10,975
Solano	136,100
Sonoma	589,390
Trinity	63,037
Ventura	223,826
Yuba	16,137
City of Berkeley	811,349
City of Long Beach	14,911
Total	$35,444,012